2005 Washington State Five Year Needs Assessment

September 2005

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Introduction

The Washington State Office of Maternal and Child Health (OMCH) has undertaken the process of creating a comprehensive strategic planning framework, involving partners within the Department of Health (DOH) and external partners, in an effort to address the needs of the MCH population. The priorities developed and process used in the 2005 Needs Assessment (NA), has been built upon the foundational results and lessons learned from the 2000 NA, and involves the three-step process of: 1) Identifying the needs of the population, 2) Assessing the capacity within the state to meet those needs, and 3) Prioritization of the needs. While the priorities will most likely remain constant over time, the activities addressing each of them are dynamic and will continue to be evaluated and adapted for sustainability.

2000 Needs Assessment: Methodological and Process Changes since 2000

The 2000 Needs Assessment consisted of the following methodology: indicator-based with a focus on MCHB Block Grant measures of morbidity and mortality, program-specific approach with three parallel processes occurring, led by MCH Assessment staff, prioritization among selected stakeholders and during retreats, with ten priorities and two overarching goals (health disparities and family inclusion). A Needs Assessment Steering Committee was identified in 2002, after a series of internal and external changes that occurred after the 2000 Needs Assessment. Externally, changes included the election of a new Governor and the resulting formation of Government Management, Accountability, and Performance (GMAP) with emphasis on performance assessment and measurable results, as well as limitations of state resources and OMCH funding. Internally, staffing changes combined with a greater emphasis on data-based decision-making, enhanced development of reports used for planning, evaluation, and policy development, and increased surveillance capacity occurred. All proved to be motivators for the creation of a strategic framework to identify the priority needs for the 2005 NA process. Valuable lessons were learned from the 2000 NA process, including: the process was too labor intensive process for sustainability, programs were inconsistent in using OMCH priorities for planning, and the process was not connected to other strategic planning efforts. Staff agreed that a more comprehensive approach to health promotion was needed. The aggregation of OMCH's vision, experience gained from the 2000 NA Process, and external/internal changes were incorporated into the 2005 Needs Assessment process.

2005 Needs Assessment: Process and Partnership Building/Collaboration

Combining MCHB guidance with strategic planning, a framework was originated. The guiding principles for the priority development included: 1) Commitment by the OMCH Management Team to lead the NA, 2) Focus on promoting health and wellness, 3) Commitment to incorporate the NA into system-wide strategic planning for OMCH, 4) Integration of work activities across all 7 OMCH

sections, 5) Involvement of staff in integrated work groups, and 6) Use of existing stakeholder groups to gather input, review process and validate results. From these foundational principles, a series of events took place within the strategic framework. To begin with, the four overall goals/population groups of MCH were identified (CSHCN, Genetics, and Immunizations were integrated among the following): healthy pregnant women and women of childbearing age, healthy infants, healthy early childhood, and healthy school-age children. Concurrently, the NA Steering Committee assessed statewide reports and activities addressing unmet needs in the MCH population. In fall 2003, NA process presentations were given to OMCH staff and managers, as well as local public health staff at MCH regional meetings (with a capacity survey to measure unmet local health needs), and Public Health Nursing Director meetings. Stakeholders were identified, and partnerships built, based on the multidisciplinary activities occurring throughout the state. Stakeholders included nurses, obstetricians, neonatologists, family practice physicians, nurse midwives, social workers from the Perinatal Advisory Committee, members of the University of Washington School of Nursing, Department of Social and Health Services staff, staff of the Women, Infants and Children (WIC) nutrition program, Regional Perinatal programs, March of Dimes, Healthy Mothers Healthy Babies, Children's Hospital and Regional Medical Center, Genetics Advisory Committee, and public health nursing directors of local health jurisdictions.

After this identification, the OMCH management team created cross-sectional workgroups consisting of assigned staff from each section, to develop priorities for each population. These priorities were developed through usage of a Logic Model (LM) framework, with staff being trained on proper LM development. After the workgroups developed their lists of priorities, these lists were distributed to the stakeholders for ranking of importance, and then were rolled up into 10-15 draft priorities per goal. Using stakeholder input, the workgroups then developed draft LMs for each priority. A strong overlap of priorities was recognized by the workgroups, which led to a merging of the original thirty into nine priority needs.

Priority Needs

The following table reflects previous and current priority needs, not in order of prioritization:

Comparison of Needs Assessment Priorities	
2005	2000
1. Adequate nutrition and physical activity	2. Improving oral health status and access to oral health care services 10. Improve nutritional status
2. Lifestyles free of substance use and addiction	9. Decrease tobacco use
3. Optimal mental health and healthy relationships	7. Improving mental health status.
4. Healthy physical and social environment	2. Improving oral health status and access to oral health care services
5. Safe and injury free environment	5. Decreasing family violence
6. Healthy physical growth and cognitive development	
7. Sexual health and sexual responsibility	6. Decreasing unintended pregnancy and

	teenage pregnancy.
8. Access to preventive and treatment services	1. Improving access to comprehensive prenatal care. 2. Improving oral health status and access to oral health care services
9. Quality screening, identification, intervention and care coordination	1. Improve access to comprehensive prenatal care. 4. Improving early identification, diagnosis and intervention services and coordination of services 3. Improving the coordination of services for children with special health care needs.
	8. Ensuring surveillance capacity for children with special health care needs.

Three priorities (9, 8, and 3) were selected for strategic planning development for the 2005 Needs Assessment, with the remaining priorities to be completed in the coming year. The motivation was two-fold: 1) Submission for the MCH Block Grant with fully developed priorities and strategic framework and 2) Comprehensive and synchronous involvement of WA State DOH staff and stakeholders in priority development and sustainability. For the three selected priorities, strategic planning retreats were convened per priority in which data and disparities were reviewed in LMs and issue briefs, current activities were reviewed and reevaluated for efficiency, and best practices and proposed activities were reviewed and discussed. From these retreats the following results were recognized: key outcomes for each priority were identified, related block grant measures were reviewed and new targets were set, new state performance measures and targets were identified, LMs were revised, and issue briefs were developed. Concurrently, in an effort to facilitate communication and reduce duplication of efforts while involving stakeholders and consumer input, the NA Steering Committee recommended communication between the 2005 NA staff and an identifiable contact person from the following assessment activities: CSHCN Road Show, Children's Mental Health Needs Assessment, Adolescent Plan Development, Growing Up Healthy, Obstetric Provider Focus Groups, First Steps Redesign, Early Childhood Strategic Planning, and Living Room Forums.

The strategic planning framework was highly successful, and also allowed for the identification of challenges to be aware of: challenge to find and consistently use Best Practices, balancing of resources with new and existing activities, political changes, satisfying the MCHB Block Grant Guidance and timeframe while allowing for appropriate priority development, and integration with other statewide efforts. Maintenance and sustainability of the strategic framework process is ultimately sought. In the next three years, the following results will be pursued and sought: priorities that apply to all populations, strategic planning accomplished and have in place continuous feedback from stakeholders, realistic targets, all staff able to understand and explain their roles and the processes of strategic planning among DOH programs, continuous data usage, continuously updated logic models, and ongoing evaluation/monitoring progress.

A. 2005 Needs Assessment Process

As part of initial planning for the 2005 MCH Block Grant Needs Assessment (NA), the Washington State Office of Maternal and Child Health (OMCH) identified a NA Steering Committee in late 2002. This committee consisted of managers and staff from several OMCH programs, OMCH Assessment, and the DOH, Office of Epidemiology health assessment liaison to local public health. The NA Steering Committee reviewed the 2000 Washington State Five Year Needs Assessment as well as NAs from several other states (AL, AZ, CA, CO, GA, MA, NC, OR, WY, WI) to revisit lessons learned and develop a process for the upcoming NA. The NA Steering Committee recognized that the 2000 process used in Washington was too labor intensive to sustain, that program planning developed from this NA had been within specific OMCH programs, and that programs had used the priorities to drive planning to a varied degree. In addition, staff felt that the previous focus on indicators, such as infant mortality or percent smoking, told only part of the story and led to the development of a limited group of activities. Staff felt that a broader focus on promoting health was needed.

The Needs Assessment Steering Committee also recognized several changes and opportunities both statewide and in OMCH since the previous needs assessment that also impacted the 2005 approach. A new Governor was elected and a management initiative called Government Management, Accountability, and Performance (GMAP) has been put in place, which focuses on performance assessment and demonstrating measurable results from state programs. The Department of Health is aligning its strategic planning as well as the Public Health Improvement Partnership plan with GMAP. The division of Community and Family Health, where OMCH is housed, is developing a strategic plan and working to better integrate work throughout the division.

Internally, a new OMCH Director was appointed and several OMCH program managers are new since 2000. State resources generally, and OMCH funding in particular, are more limited. Data-based decision-making is more prevalent throughout DOH, OMCH surveillance capacity has grown, and several recently completed and/or annual MCH reports are regularly used by staff for planning, evaluation, and policy development. Furthermore, integration of services and databases, as well as concerns about boosting efficiency and not duplicating efforts, have spawned an environment where staff are ready to take a broader strategic look at OMCH planning and program development. As a result, OMCH decided to conduct the Needs Assessment (assess needs, examine capacity, select priorities, set targets, identify activities, and allocate resources) within a strategic framework. We asked ourselves:

- Where are we now?
- Where do we want to be?
- How do we get there?
- How do we track progress?
- How do we measure success?

This appraisal led to the development of a set of principles to guide the 2005 NA process. These principles included: 1) commitment by the OMCH Management Team to lead the NA, 2) commitment to incorporate the NA into system-wide strategic planning for OMCH, 3) integration of work activities across all 7 OMCH sections, 4) data based decision-making, 5) use of existing stakeholder groups to gather input, 5) focus on promoting health and wellness, and 6) commitment to developing an ongoing needs assessment/strategic planning cycle.

To reduce duplication of efforts, OMCH began a general needs assessment process that was integrated with several assessment and planning efforts already underway. First, the general needs assessment process will be described and then the other planning efforts and how they were integrated will be described.

Initially, the NA Steering Committee reviewed and cataloged assessment activities and reports from across the state to identify unmet needs of the MCH population in an effort to inform the NA process as well as to prevent duplication of existing efforts. At the same time, throughout fall 2003, a series of presentations were made by the Needs Assessment Steering Committee members to OMCH staff and managers to orient them to the rationale for the Needs Assessment, to introduce the goals and principles guiding Washington's needs assessment process, to gather ideas for determining the process for identifying priority needs, and to encourage staff to participate in the process. Shortly thereafter, presentations were made to local public health at MCH regional meetings and Public Health Nursing Director meetings. Presentations to local public health also included a capacity survey which gauged unmet needs and capacity issues at the local level. (See Appendix A)

After these introductory presentations and data collection efforts, workgroups were formed within the OMCH to begin developing priorities for each of the four MCH populations: pregnant women and women of childbearing age, infants, young children (1-5 years), and school age children (6 -18 years). Each workgroup had staff from every section of OMCH in order to promote integration. In identifying needs, the workgroups were challenged to answer the question, "What do we need to do to create/have a healthy "_____" (insert: pregnant woman, infant, young child, school age child) population in Washington State? To answer this question, they were asked to consider:

- What does a healthy "____" population looks like?
- What do we know about "____" in Washington?
- What do we need to do to promote healthy "____"? What are we already doing and what still needs to be addressed?
- What kinds of strategies or goals if accomplished would promote healthy "____"?
- What is Washington's ability to do this work? What is the DOH role in this work?

EXAMPLE:

- What does a healthy pregnant woman look like?
  - Healthy, safe…….
- What do we know about pregnant and reproductive age women in WA?
  - Explore data on lbw, preterm delivery, smoking in pregnancy, etc.
  - Look at disparities by geography, race/ethnicity, urban/rural, age, women w/special needs, SES, etc.
- What do we need to do to promote healthy pregnancies?
  - Smoke free, prenatal care, Social support systems, Adequate Nutrition, Etc.
- What kinds of strategies or goals if accomplished would promote healthy pregnancies? Identify what we are already doing and what still needs to be addressed:
  - Prenatal care:
  - Health insurance for all pregnant women; adequate number of providers, etc.
- What is Washington's ability as a state to do this work? What is the DOH role in this? Identify capacity to address both current and new strategies.
  - Health insurance:
    - Eligibility, benefits, etc.

Each workgroup developed its own process to answer these questions and identify subpopulation priorities.. All workgroups reviewed the 2000 MCH priorities and current Block Grant activities to begin their process. They were provided a guidance document for identifying needs, assessing capacity and establishing priorities. (See Appendix B) The guidance encouraged staff to use recently published data reports, including: the MCH Data Report, Pregnancy Risk Assessment Monitoring System (PRAMS) Reports, Key Indicators of Perinatal Health Report, Healthy Youth Survey Reports, Childhood Injury Reports, Adolescent Fact Sheets, Health of Washington State, MCH Rural Health Monographs, as well as findings from the National Child Health Survey and National Children with Special Health Care Needs Survey. The guidance provided information on how staff could consider the size and seriousness of health issues as they reviewed their data. The guidance also suggested ways to assess capacity by considering the availability, affordability and accessibility of direct and enabling services and stressed that existing stakeholder groups and consumers should be incorporated into the process whenever possible.

The processes for identifying priorities among the Pregnant Woman and Woman of Childbearing Age Population Workgroup and the Infant Population Workgroup were very similar due to the substantial overlap of members. Each workgroup reviewed the priorities identified five years ago, current Block Grant activities and performance measures, and priorities recently identified by stakeholder groups. Stakeholder groups that had already been polled by MCH staff included the statewide Perinatal Advisory Committee and selected local health jurisdictions. In addition, the First Steps program, which provides maternity support and intensive case management to pregnant women and infants, was in the process of being redesigned and had undergone substantial review of activities and identification of priorities for this process. Information gleaned from this process also informed the development of priorities. One member of the workgroup further organized and listed potential priorities for these two population groups by assessing MCH activities currently underway. The documents used to ascertain current priorities included activities from the MCH Block Grant and current performance measures, the

MCH Rural Health monograph, the Perinatal Indicators Report, and the Health of Washington State document. Members of the workgroup then added additional priorities to this start list. They used documents important to their programs such as the Immunization Program data, the MCH Data Report, the CSHCN Road Show document, Genetics Advisory Committee documents, the 2004 Physician Focus Group report, the 2003 Washington State Needs Assessment survey, Living Room forum data, Lessons Learned document, community disability projects, community disability board meeting (DASH) minutes, Early Hearing Loss Detection, Diagnosis and Intervention (EHDDI) conference evaluations, Health Disparities Task Force minutes, census data, Minimum Data Set (genetic services utilization data from WA genetics clinics), American Association of Pediatrician recommendations, Joint Committee on Infant Hearing documents, and the Telemedicine feasibility study.

Workgroup members met and collaborated on a more succinct list of perceived priorities. Stakeholder groups were asked to prioritize this list. (See Appendix C) Workgroup members suggested stakeholder groups based on their cross-program and multidisciplinary activities conducted across the state. Stakeholders included nurses, obstetricians, neonatologists, family practice physicians, nurse midwives, and social workers from the statewide Perinatal Advisory Committee, members of the University of Washington School of Nursing, Department of Social and Health Services staff, staff of the Women, Infants and Children (WIC) nutrition program, Regional Perinatal programs, March of Dimes, Healthy Mothers, Healthy Babies, Children's Hospital and Regional Medical Center, Genetics Advisory Committee, and public health nursing directors of local health jurisdictions.

A list of priorities for "the healthy infant" and for "pregnant women and women of childbearing age" was sent by email with a cover letter from the MCH Director to approximately 60 stakeholders. About 15 responses were received from stakeholders which were used to identify 10 priority "domains" for healthy pregnant women and an additional 7 priority "domains" for healthy infants. The healthy pregnant women priority domains include:

- tobacco-free women
- appropriate alcohol use/drug-free women
- sexually responsible and healthy women
- healthy relationships
- safe and healthy environment
- adequate nutrition
- access to care
- high quality prenatal care
- high quality care for women of reproductive age
- healthy lifestyle including physical activity.

The healthy infant priority domains include:

- adequate nutrition
- safe and healthy environment
- promote fine and gross motor development, cognitive development and communication skills
- promote positive social/emotional development
- access to well-child care
- promote medical homes
- promote medical insurance coverage.

The Young Child Population Workgroup organized an initial list of priorities for this population using a framework developed for the Washington State Early Childhood Comprehensive Systems planning grant. This framework divided early childhood needs into components: Physical Health, Oral Health, Social-Emotional/Mental Health, Cognitive Development, Motor Development, and Language Development. Each work group member took one component and identified two or more priorities based on stakeholder input and/or research literature. The results were compiled into a first draft of priorities for the young child population. The draft priorities were sorted into Health Promotion, Primary Prevention, Early Identification and Intervention, Care Coordination, and Medical Home. Stakeholders were then identified to review the list. A total of 41 stakeholders were sent the list and asked to rank each priority as high, medium, or low as well as to provide any comments. Nineteen responses were received and were used to identify six priority "domains" for the young childhood population:

- adequate nutrition
- early identification
- mental health
- child abuse and neglect prevention
- school readiness
- safe and healthy kids.

The School Age Child Population Workgroup used its work as a member of the multidisciplinary Washington State Partnership for Youth (WSPY) as a basis for developing priority areas. One of WSPY's goals is to recommend a comprehensive set of actions and strategies that will improve the health and well-being of Washington's youth. Members of WSPY's Needs Assessment Committee met over several months and reviewed data on Washington State youth. They identified the following priority areas.

- drug and alcohol use
- tobacco use
- physical growth and development
- emotional growth and development
- intentional injury
- unintentional injury
- teen suicide
- eating disorders
- nutrition
- physical activity
- sexually transmitted diseases
- teen pregnancy
- sexual behavior
- sexual identity
- teens with special needs and disabilities

MCH staff polled other stakeholder groups regarding priority health issues for school age youth. Stakeholder groups included family planning providers, school nurses, selected local health jurisdiction staff, injury prevention programs, tobacco prevention and control programs, and health care plans.

Several responses were received from stakeholders. Priorities were evenly distributed across all choices and demonstrated clear preference for these priorities. Based on this information, the workgroup used the lists of priorities to formulate "domains" for categories:

- sexuality
- nutrition and physical activity
- substance abuse
- mental health
- environmental health

- injury prevention
- growth and development

Workgroup members were also trained in logic model development. (See Appendix D for an example of two logic models developed) They were asked to develop a logic model for each priority need they identified for their subpopulation to facilitate the process of going from 30 priorities across the 4 workgroups to 10 priorities for the entire MCH population. Logic models identified the available resources, activities (current and proposed), outputs from the activities and short, intermediate, and long term outcomes for their activities. Data on health status indicators, federal and state performance measures, federal outcome measures and outputs were included in the logic models as were Healthy People 2010 goals. Once the logic models were drafted, it became clear that there was substantial overlap across the priorities identified by the subpopulation workgroups. So, by early fall 2004, the subpopulation priorities were combined into nine priorities for the entire MCH population (See Appendix E):

- Promote adequate nutrition and physical activity
- Promote lifestyles free of substance use and addiction
- Promote optimal mental health and healthy relationships
- Promote a healthy physical and social environment
- Promote a safe and injury free community
- Promote healthy physical growth and cognitive development
- Promote sexual health and sexual responsibility
- Promote access to preventive and treatment services
- Promote high quality screening, identification, intervention and care coordination.

Over the past nine months, MCH managers have focused strategic planning around these priority areas. Since it was not possible to tackle all nine priorities by the MCH Block Grant due date, the group has focused on three priority areas with the understanding that strategic planning for the remaining six areas will occur over the next year. The priority areas for which strategic planning has been completed include: 1) Promote high quality screening, identification, intervention and care coordination, 2) Promote access to preventive and treatment services and 3) Promote positive mental health and healthy relationships.

Strategic planning has involved MCH managers undertaking the following tasks:

- Reviewing data and disparities in logic models.
- Reviewing current activities across all population groups. Identifying activities with a compelling reason to continue, and activities with a compelling reason to reduce work or discontinue, and opportunities for integration.
- Continuing to update logic models with missing information.
- Reviewing proposed activities, best practices noted on logic models or from literature, and identifying any compelling new activity to undertake.
- Identifying opportunities for implementing a more integrated approach within OMCH (including any proposed new activities).
- Identifying key outcomes for each priority where OMCH agrees to focus efforts over the next 5 years.
- Reviewing related performance and outcome measures and establishing new targets.

- Identifying new state performance measures and establishing targets.
- Revising logic models to reflect decisions regarding changes in activities and performance/outcome measure targets.
- Developing summary Issue Briefs to communicate decisions and status of work on priority areas (Appendix F).
- Planning for integrating this into a systematic cyclical assessment and review process.

At the same time that OMCH was involved in the 2005 MCHBG Needs Assessment, other focused needs assessments and planning efforts were already underway. To take advantage of lessons learned through these processes, the Needs Assessment Steering Committee identified a staff person to act as a liaison between these other activities and the 2005 NA to facilitate communication, reduce duplication of efforts and gather as much stakeholder and consumer input to the 2005 NA as possible. These activities are described below.

CSHCN Road Show

This project, conducted over 6 months during 2004, was an effort to engage public health stakeholders in the use of National Survey of CSHCN (NS-CSHCN) results to improve systems of care for children with special health care needs. Seven "CSHCN Road Shows" were conducted with local health departments, state agencies, families, health plans, neurodevelopmental centers and school nurses. These presentations were focused discussions built around PowerPoint presentations of state data from the NS-CSHCN. They were used to present and validate Washington state findings from the NS-CSHCN, obtain input on additional topics for analysis and elicit ways of incorporating NS-CSHCN results into the state's 2005 NA and strategic planning efforts and policy development.

Children's Mental Health Needs Assessment

This project from September 2004 to June 2005 was a collaborative effort between the CDC's Public Health Prevention Service and OMCH. The children's mental health needs assessment was developed and implemented for several purposes: 1) to define the role of public health in mental health; 2) to ascertain prevalence of mental illness diagnoses, risk factors, and protective factors among children; 3) to identify groups of children at risk for mental illness; and 4) to develop a framework for future mental health needs assessments. Washington State data, prior research, and literature were analyzed to distinguish trends in mental health and mental illness among specific populations of children. Key informant interviews were held once the data analysis was complete in order to inform the data and assess Washington State's capacity to meet the mental health needs of children. Interview questions were drafted and reviewed by members of the CFH Mental Health Workgroup. Key informants were selected by the CFH Mental Health Workgroup based on region, provider focus, and population. Of the 55 key informants selected for the interviews, 52 participated. Participants included community psychiatrists, social workers, public health nurses, educators, child care professionals, administrators, mental health therapists and child welfare professionals. Interviews occurred over a two-month period and were performed in person by a CDC public health prevention specialist. Findings will be used to inform an OMCH priority around social, emotional and mental health as well as provide a backdrop for developing an OMCH mental health strategic plan.

Adolescent Plan Development

This project begun in 2003 is slated to be completed in 2006 as part of Washington Department of Health's role as a member of the Washington State Partnership for Youth (WSPY). WSPY is engaged in a statewide needs assessment and strategic planning process in order to develop a plan recommending a comprehensive set of actions and strategies to improve the health of Washington's youth. The process for developing the plan has included a Needs Assessment Committee that identified, gathered, and analyzed data on adolescent health needs in the state of Washington. The objective was to create a profile of the adolescents living in Washington, to describe the current status of adolescent health, and to identify gaps and barriers to health. The results of this Needs Assessment, which includes both quantitative and qualitative data, will be used in the development of the comprehensive Washington State Adolescent Health Plan.

The Needs Assessment Committee consisted of members from multiple organizations, agencies or associations and geographically dispersed across the state. Most self-initiated membership through recruitment from WSPY. Some members were specifically recruited because they represented an organization or state location that was underrepresented. The committee met bi-monthly from January 2004 through August 2004 and presented initial findings in July 2004. The WSPY steering committee provided oversight and guidance to the Needs Assessment committee throughout the duration of its existence.

Growing Up Healthy

This project, conducted in 2004, was part of our larger Sexual Abstinence Education Program, funded by DHHS/HRSA/Maternal and Child Health Bureau. The purpose of the Growing Up Healthy project was to better understand what is needed to promote and support healthy and successful teens in Washington, as well as assess perceptions by youth and parents regarding media messages on sexual abstinence and positive youth development. Twelve focus groups were conducted in 6 cities statewide with 10-14 year-old teens and with parents of 10-17 year-olds. Overall 236 participants were recruited through community contacts by local public health staff and staff at community-based agencies. Focus groups were facilitated by trained facilitators. Participants also completed a brief demographic survey immediately prior to each group.

Obstetric Provider Focus Groups

In 2004, OMCH conducted a focus group study with obstetric providers to determine physician perceptions of prenatal substance use and domestic violence screening and the effectiveness of various provider training approaches. Semi-structured phone interviews were conducted with eight obstetric providers randomly selected from a statewide provider database to develop questions for the focus groups. A total of six focus groups were held and 28 randomly selected physicians participated. Four focus groups were in person – two each in eastern and western Washington and two telephone focus groups were held with providers who serve rural populations.

First Steps Redesign

In October 2003, the First Steps program which provides support and case management services to low-income pregnant women and infants was revised to improve quality of care, contain costs, and tie intensity of services to client need. Much of the feedback received by service providers before this revision was put into place as well as evaluation of the revisions have informed the MCH Five Year Needs Assessment. OMCH worked in partnership with the Medical Assistance Administration and service providers to develop the redesign.

Early Childhood Strategic Planning

In 2003, Washington OMCH received a 2-year Early Childhood Comprehensive Systems Grant from HRSA for strategic planning to develop systems to help young children be healthy and ready to learn by school entry. With this funding, OMCH took the lead in staffing a statewide multi-agency strategic planning effort to build a comprehensive early childhood system. Input to the planning was collected from a team internal to DOH, with representation from all OMCH sections and the following programs outside of OMCH: injury prevention, tobacco prevention, physical activity and nutrition, WIC, lead program, food safety, emergency medical services and emergency preparedness. An external planning team staffed by OMCH with representatives from 30 programs, organizations and community groups at both the state and local levels provided substantial guidance and communication/integration with a variety of other statewide initiatives also focused on early childhood. A few of the partners represented on the external group included Headstart, Infant/Toddler Early Intervention, Center for Infant Mental Health, Washington-Parent Education Network, Bright Futures of Whatcom County, King County's Kids Get Care program, and many others. Reports from across the state were reviewed to highlight strengths, gaps and access issues for the five key content areas: medical homes, mental health/social emotional development, child care/early childhood education, family support, and parenting education. Two additional topic areas were also addressed: communication and governance. The planning groups identified and prioritized outcomes at the child, family and system levels for each of these areas as well as indicators to monitor outcomes. An application for the implementation phase of the grant from 2005-2008 has been submitted to HRSA.

Living Room Forums

From April to November 2004, OMCH contracted with Publicis Dialogue to conduct 15 facilitated group discussions in community settings across the state focusing on one of three topics: newborn screening, equity of genetics services, or genetic discrimination.

All of the above activities have been integrated into the OMCH overall Five Year Needs Assessment by 1) including concerns raised in the development of the subpopulation priorities; 2) incorporating findings from these activities into appropriate logic models described previously; and 3) communicating feedback from these efforts and lessons learned at OMCH strategic planning sessions.

B. 2005 – 2009 MCH Priorities

As part of the 2005 MCH Five Year Needs Assessment, the MCH Office has spent the last six months identifying priority needs for pregnant and childbearing aged women, infants, young children and school aged children in Washington. To articulate these needs, we began by asking the question, "What does a healthy MCH population look like?" Workgroups were established for each MCH subpopulation: pregnant and childbearing aged women, infants, young children (0-5 yrs), school aged children (6-18) yrs. As each of these workgroups answered this question for their population, similar themes emerged that embodied several long term goals for a healthy MCH population. These long term goals are now recognized as our MCH priorities. They are the broad goals we work towards in our day to day activities.

We recognize that each of these priorities (listed below) is broad and may include work both our DOH and external partners undertake. However, our purpose in identifying these priorities is to focus on the MCH role in each of these long term goals. As we continue to work on the 2005 Five Year Needs Assessment and long term planning, we will work on strategically reviewing our current activities addressing each of these priorities in an effort to 1) better integrate our activities across the MCH Office and DOH; 2) realize efficiencies across activities; and 3) identify priority activities for addressing these goals. We anticipate that our priorities for a healthy MCH population will remain fairly constant over time; however, the activities we undertake to address them will change as progress is made and/or new issues emerge.

Priority 1. Promote adequate nutrition and physical activity

> This priority focuses on promoting food security and adequate nutrition for the entire MCH population as well as use of folic acid for pregnant women and women of childbearing age. Emphasis is placed on promoting healthy weight, decreasing hunger and increasing access to healthier food choices for the population. It also focuses on promoting physical activity for the entire MCH population.

Priority 2. Promote lifestyles free of substance use and addiction

> This priority focuses on preventing the use of, and educating about tobacco and illicit drugs among adolescents, pregnant women and women of childbearing age. It also focuses on preventing alcohol use among adolescents and pregnant women, and promoting responsible alcohol use among women of childbearing age.

Priority 3. Promote optimal mental health and healthy relationships

> This priority focuses on supporting healthy relationships among the entire MCH population. This includes promoting healthy relationships throughout the lifespan including an understanding of the social/emotional development of children from birth through adolescence. Specific activities support first relationships between infants and caregivers, helping parents be better prepared for parenting, developing healthy relationships for youth, fostering access to mental health services, promoting safe relationships within schools, and reducing and preventing domestic, family and youth violence.

Priority 4. Promote a healthy physical and social environment

This priority focuses on promoting healthy physical environments (food, air, water, and land) as well as promoting built environments (eg, land use planning, road planning, sidewalk development, and building design) that promote physical health and positive social interactions.

Priority 5. Promote a safe and injury free community

This priority focuses on promoting communities that minimize intentional and unintentional injuries, including child abuse and neglect.

Priority 6. Promote healthy physical growth and cognitive development.

This priority focuses on promoting an understanding of the developmental milestones from birth through adolescence and how these impact long term growth and development including communication, school readiness

Priority 7. Promote sexual health and sexual responsibility

This priority focuses on promoting sexual health of adolescents by decreasing adolescent risk taking associated with early onset of sexual activity. It also encourages adolescents to delay sexual activity while fostering healthy relationships. Finally, this priority focuses on promoting access to STD screening and family planning services for sexually active adolescents, women of childbearing age and pregnant women.

Priority 8. Promote access to preventive and treatment services

This priority focuses on promoting availability, affordability and accessibility of both preventive and treatment services and insurance coverage for the MCH population. Services include: primary care, well child/woman care, prenatal care, medical homes/care coordination, oral health, mental health, family planning and substance abuse.

Priority 9. Promote high quality screening, identification, intervention and care coordination

This priority focuses on promoting high quality care for the MCH population. For children and adolescents, it promotes screening, identification and intervention for physical and developmental disabilities, neurological disorders, social, emotional and behavioral challenges, and chronic and non-chronic health conditions among children and adolescents. It also includes promoting medical home practice, care coordination, Early Periodic Screening, Diagnosis and Treatment EPSDT visits, and promotion of children receiving the full schedule of immunizations.

For pregnant women, this priority focuses on best practices for prenatal care provision including identification and management of health conditions (e.g, hypertension and diabetes); tobacco use; substance abuse and violence identification, treatment and prevention; HIV testing and counseling; genetics education and appropriate referral/counseling; immunization coverage; high risk delivery management; nutrition and breastfeeding counseling; parenting education, and emerging perinatal issues. For women of childbearing age, this focus includes screening, identification and management of chronic health conditions including hypertension, diabetes, obesity, genetic conditions, substance abuse, and mental health disorders, as well as promoting safe and effective contraception.

Appendices

Appendix A: Capacity survey results
Appendix B: Section Guidance to staff
Appendix C: Letter to local Public Health Nursing Directors and stakeholder surveys
Appendix D: Two logic models as examples
Appendix E: Combined list of priorities collapsing the 30 logic models into nine priorities
Appendix F: Issue briefs developed to date

Appendix A: MCH Five Year Needs Assessment Capacity Survey of MCH Regional Teams Fall 2003

In the Fall of 2003, presentations were made at four of the five regional MCH Team meetings across Washington State. Presentations were accompanied by facilitated discussions in order to both orient local health staff to the 2005 MCH Five Year Needs Assessment and gather their input on MCH capacity issues across the state. MCH Teams consist of staff from across the Office of Maternal and Child Health who provide technical assistance on MCH issues to local health jurisdiction staff statewide. They convene regional meetings regularly (quarterly or three times a year) with local health staff in their respective regions to facilitate communication, coordination and education between the state OMCH and local MCH staff.

As part of the facilitated discussions, local team members were asked:

1) to identify issues that OMCH should not miss in collecting information on our state's ability to address MCH needs
2) to identify the best mechanism for OMCH gathering in-depth information from local MCH staff

What follows is a summary of the responses received.

Key Themes Identified from Capacity Survey:

- **Oral Health:** Oral health/ dental health services for women and children, insurance coverage for oral health care; ABCD program; fluoridation.

- **Mental Health:** Assurance of availability and access to quality infant, child, and maternal mental health resources; funding for treatment of pregnant/ parenting women and infants/ children; youth services; barriers in the system restrict access.

- **Medicaid**: Declining and fluctuating coverage; lack of dental care coverage; co-pays as barrier to services; restricted coverage; need for coverage for undocumented.

- **CSHCN:** Insurance coverage; improve access to care; reduce bureaucracy; funding issues; working with schools; improved coordination in schools.

- **Childcare:** Loss of funding; need for quality available child care; insurance coverage; access to care; funding; working with schools; provider training.

- **Access to care:** improve access for low income and undocumented; improve access to specialists; improve access for CSHCN; need for early prenatal care; need for oral health care; support services for MSS/ICM; improve mental health access.

- **Issues Related to Disparities:** Access to specialists in rural areas; access to care for low income and undocumented MCH population.

- **Undocumented:** Medicaid coverage needed; need to address diversity issues.

- **Nutrition:** Nutrition and role in health; working with schools and WIC.

- **Early Prenatal Care:** Need for early PNC services; support services for MSS/ICM; first trimester PNC may not be the best measure of access.

Best Way Identified for getting in-depth information from MCH regional team member of MCH staff in your office: On-line survey and facilitated discussion at MCH team or other meeting

Other comments / issues of note:

- I feel it is very important to know how successful our state has been in meeting the "priority" needs identified in the last 5 year Needs Assessment. If you have preliminary information it would be good to share that so that decision makers can decide to continue support or change priorities.
- Literacy
- Simplifying the bureaucracy
- Expand availability of vaccines for all children.
- Increase home visiting
- I want to remind you of the importance of addressing the health needs of students in our public school system, both in terms of increasing numbers of students with health issues (e.g. increasing numbers of children with diabetes and asthma), and also of increasing need for health services due to changing regulatory requirements (e.g. life threatening illness, students with diabetes, and hepatitis C bills passed during last two legislative sessions).
- Child abuse and neglect- leads to lifetime of problems- how can we tap into this? What are services for children and proven interventions?
- MCH not mandated- when budget cuts some around, we are vulnerable. Can there be some legislation mandating MCH services?
- Methamphetamine use- look at separately from other drugs
- Preconceptional health

Comments Related to the Needs Assessment:

- Prioritization process – include regional MCH team meetings in process
- Possible place for more NA work with MCH staff: Spring regional MCH Conference- lunch roundtables an idea (April meeting)
- Need to make sure include consumers and hard to reach populations throughout process i.e. people of color, GLBT, etc.
- Look at reports and studies already going on and include that information.

Note: See Following Pages for Detailed Responses

Question: What issues should we make sure we do not miss in collecting information on our state's ability to address MCH needs (e.g., in the last five year needs assessment, one focus of inquiry was the impact of managed care on access, another was welfare reform)?

Respondent	Comment
Skagit	▪ Fluctuating Medicaid eligibility for children rather than being locked in for a year.
King	▪ Impact of declining Medicaid and Basic Health coverage (premiums, copays, deductibles etc) on health of children, particularly children with special health care needs who are ineligible for Medicaid.
Whatcom#1	▪ I feel it is very important to know how successful our state has been in meeting the "priority" needs identified in the last 5 year Needs Assessment. If you have preliminary information it would be good to share that so that decision makers can decide to continue support or change priorities.
Grays Harbor	▪ Please include access to care for low-income, undocumented children, especially those with special needs. Include language barriers in Spanish-speaking populations when seeking care. Most of the providers and hospitals in our area do not use interpreters or have the ability to serve non-English speaking populations appropriately. ▪ Also include recent changes to Medicaid and Basic Health, how the co-pays and premiums will affect access. Broad-ranging effects are predicted. The community health centers anticipate that families will fail to pay co-pays and premiums and will go on sliding fee scale instead, which will severely restrict the usual funding by Medicaid reimbursement they rely on. Other families might find the sliding fee scale minimum amount more reasonable than the co-pays or premiums. Hospitals might find that they are serving children through the ER without revenue due to falling off Medicaid rolls when families cannot keep up with the co-pays and premiums. ▪ Another issue is access to specialists for children in rural areas. ▪ Dental care and access for children remains a huge issue. Most providers (medical and dental) have no idea how to serve infants and children under 3 years of age, yet there is more of a push to begin serving them early. Many children with Medicaid still don't have access to dental care.
Mason :	▪ Categories of CSHCN disabilities- information on what can do to prevent disabilities (effective interventions)
Central #1:	▪ diabetes ▪ Oral health and access and early intervention ▪ Oral health access for mothers
Central2:	▪ Literacy ▪ Undocumented children. ▪ Access to care and seasonal employment efforts on insurance
Central3:	▪ Preliminary findings in Yakima of increased gestational diabetes over past 10 years, especially Hispanic population indicate good reason to look statewide.

Central #4: (School nurse corps)	▪ Adequate Mental Health Services – access and availability ▪ Improve coordination in each location for students with complex health situations. ▪ Improve nutrition and activity in communities (schools!)
Kittitas:	▪ Of course, now we have the problem of no Medicaid for undocumented families. So far, I have had only one referral for this issue, and that person is now over 18, but I know for example that the woman who works for the local school district with migrant and Hispanic families would be a good resource for information in our county. ▪ We should also be looking at how many providers, including dentists, will take medical coupons and how many won't.
Whatcom#2	▪ In Whatcom county I collected information when pregnant women enrolled in First Steps about whether their pregnancy was planned or unplanned. My "outcomes" were vastly different from PRAMS but is there any point in sharing this information with anyone except local agencies? This data helps us locally to plan programs. ▪ Perhaps if Washington adapts a system, like Omaha, you would get information out would not get anywhere else. ▪ In our population of pregnant women, the highest needs remain for dental care and early prenatal care. Depression is identified often but women frequently don't want help. The Take Charge program that pays for birth control is wonderful and are used to keep birth control affordable and accessible to all men and women. The loss of child care funding for special needs left a huge hole.
Whatcom#3	1. Simplification of the bureaucratic maze!!!! I'm a professional working in this system and it's overwhelming to me to try and understand the pile of confusing letters that two of my client families with Children with Special Health Care Needs (CSHCN recently received from SSI and DSHS. I can't begin to imagine how it must be for these families who are literally struggling day to day to keep their medically fragile children alive. Simple things like explaining abbreviations (like CSO) used in letters would help. Coordination of the two programs would really be nice. Clients need to be told that just because they give written notification of a change in circumstance to one part of DSHS, they can't assume that other programs (e.g.,childcare section) will receive that information, so they are expected to notify each program separately. Of course, it would be much better if the system was set up so that a client could be assured that if they notify one department, that info would be distributed to all programs with which the client is involved. 2. Reduction of one-size-fits-all procedures If a Work First client has an extensive employment history including fairly professional/high level work,it's unnecessary to require her to attend more than once a long training session regarding very basic job search skills, including personal hygiene habits. 3: Improved access to mental health services Perhaps channeling some of the mental health funds for a certain number of treatment slots for pregnant/parenting women and for infant/child mh services. MSS staff could then coordinate with local community m.h. clinics. 4: Access to dental care 5: Reduce bureaucratic redundancy so that the system could afford to provide CSHCN with better hearing aids

Whatcom#4	Several more of my staff who are on the front lines responded to my request for suggestions so I will summarize: 1) Substance use/abuse support to quite, esp. smoking and alcohol. 2) Mental health services--esp access to appropriate treatment and medications 3) Support services such as MSS/ICM 4) Early access to prenatal care by MD providers 5) Injury prevention efforts esp with car seats, bike helmets (the graduated driver's licensing is working!) The efforts of BUCKL-UP have gotten car seats into thousands of cars and in Whatcom Co. we have had NO deaths of an infant in car crash--a huge improvement since the mid 90's. 6) Huge # of children are in out of home placement so supporting top quality child care is critical for the health of this population. Funding for child care and services that train child care providers to improve their skills(at low or no cost)--they need to know about back to sleep, ways to stimulate early brain development, they also need supports that were largely removed earlier this year--additional care providers when someone is out ill, help with special needs children. 7) Expand the availability of vaccines for all children. 8) Emphasis on the importance of fluoride to preventing dental decay and continued ABCD dental programs that enable young children and sometimes their parents to be connected to a dentist. 9) Nutrition and it's role in health. More and more young families are growing up with fast food and box food--they don't know how to cook! Continue WIC programs and nutrition in school and early head start.
Whatcom#5	1. Less cumbersome Healthy Options System/easier access to care: Many clients get confused about plans and primary care providers. They get even more confused when they must switch plans to switch providers, or if mom wants she and baby to have providers from different plans... 2. Easier access to mental health services: I had a First Steps client who needed counseling, but couldn't get it without PCP referral. A referral from professionals who knew her (OB, PHN, MSW) wouldn't do. She needed to have a new patient appointment with PCP to get a referral. I see this as a major, costly barrier to access. 3. Access to longer-term relationships with caring professionals who can visit clients in their homes if necessary: No matter what services are available, some of our clients are so young and/or wounded that they can't get it together to figure out what they need or to access services on their own. These folks need someone in it for the long haul; someone who is willing to build a trusting relationship and start where the client is at. A recent MMWR review concluded that research evidence supported home visiting as an effective intervention to prevent child maltreatment. It's interesting to me that the findings held true across many kinds of home visiting programs. Makes me think maybe it's the relationship and not the program focus that is the real intervention.
Unknown	▪ Dental care ▪ Mental Health Infant/ youth especially ▪ How many Workfirst parents sanctioned due to lack of appropriate child care or moms in school to increase skills and increases potential income
Unknown	▪ Shortage of available housing- long waits for housing authority subsidy approval ▪ Racial and ethnic diversity issues- needs of undocumented MCH clients

School Nurse (SW)	I am not MCH staff, but want to remind you of the importance of addressing the health needs of students in our public school system, both in terms of increasing numbers of students with health issues (e.g. increasing numbers of children with diabetes and asthma), and also of increasing need for health services due to changing regulatory requirements (e.g. life threatening illness, students with diabetes, and hepatitis C bills passed during last two legislative sessions).
Cowlitz	Assurance of availability and access to quality infant, child, and maternal mental health resources
Thurston	• The continuing problem of access to local general medical care with a primary care doctor • Non existent Dental access • Medicaid families having to pay a monthly premium and co-pays

Verbal Comments at Team Meetings:

Team	Comments
SW Team Meeting (12/12/03):	▪ MCH not mandated- when budget cuts some around, we are vulnerable. Can there be some legislation mandating MCH services? ▪ Prioritization process – include regional MCH team meetings in process ▪ Prenatal care (first trimester) : not the best measure- we willnever meet it. Many MDs won't see patients until the 12th week of pregnancy. Pregnant women do get access to services earlier though such as WIC ▪ Include men in NA population
NW Team (9/24/03)	▪ Thanks for seeking input early on in the process- appreciated the opportunity to have input into the development of indicators, versus last time when their input was solicited at the end during the priority setting process. ▪ Indicators: o Please include the PPOR analysis done by Seaking (What has DOH done with this? There is useful information in the analysis) o Please include women's preconceptual health indicators (such as chronic disease, physical activity etc., Ellen Hutchins at MCHB has done some work on this) ▪ MCH Assessment Notebook- there were some requests for updated data for the MCH Assessment Notebook put out in 1995: o I have been waiting for those tables to see if I am having an effect. o This book was very helpful to refer to- I still use it. o We use the notebook as a basis for our community assessment. o Please update the tables. o Please put them on the web so we can download them. o Both small and big counties expressed an interest in us producing county level data (including Vital Stats as well as Child Abuse referral rates and other resources). ▪ Possible place for more NA work with MCH staff: Spring regional MCH Conference- lunch roundtables an idea Need to make sure include consumers and hard to reach populations throughout

Team	Comments
	process i.e. people of color, GLBT, etc. How to access those folks
Central (11/6/03)	Group discussed how MCH can ensure that we are getting the best information to establish priorities to meet the needs for the populations we serve. • Chelan-Douglas reported that lots of MCH data is already getting collected and sent to the state office. Local MCH programs want it to come back in a helpful way that we can use it. if mapped could drive service. Local MCH programs do not have the capacity to develop reports, etc. • Further interpretation needs to happen that addresses, " what does this data mean to us?" and then compare to other counties, then state. • Connect with : 1. Existing Health district assessments, including the new steps grant. 2. WIC 3. Schools (Pre-school,0-3) 4. Head start 5. Other MSS agencies, that are not public health 6. Clinical arena 7. Farm workers Community Health Clinic 8. Tribes 9. Women's Health coalition (Walla-Walla) 10. Association of dentists and 11. Health plans, both managed and commercial 12. Yakima Valley Memorial Hospital: Mary Hart is using the BERD file to look at interesting indicators that she thinks should be included in needs assessment Group reviewed indicator list and reported that we include indicators that look at: • Meth separately from other drug use • Literacy level for all populations
Olympic (11/31/03)	▪ CSHCN- ID problems that are preventable, data on prevalence and preventable risk factors ▪ Summarize data from CSHCN database ▪ BD registry data ▪ Child abuse and neglect- leads to lifetime of problems- how can we tap into this? What are services for children and proven interventions?

2. What is the best mechanism for getting in-depth information from you and/or other MCH staff in your office?

	Facilitated discussion at MCH team or other meeting	On-line survey	Paper survey	Phone Interview	Other/ Comments
Skagit	1			1	Attending one of our MCH staff meetings would be great, but probably not practical.
King		1			
Whatcom			1		
Grays Harbor		1		1	
Mason	1				
Central #1-4	3	3	2	1	Variety is best – start with the online or paper survey then follow up with focus groups to clarify and validate your understanding of the survey results
Kittitas		1		1	
Unknowns		2			
Cowlitz		1			Develop survey using previous reports as a guide. Develop online data collection system based on above survey results
Thurston	1	1			Regional meetings work well for discussion; on line survey is OK just for information
Total	**6**	**10**	**3**	**4**	

Appendix B: Section Guidance for Five Year Needs Assessment Process

Introduction:

The MCH Block Grant Needs Assessment is a three-step process:

1. Identifying the needs of the population (September 2003 – February 2004);
2. Assessing the capacity within the state to meets those needs (September 2003 – February 2004); and,
3. Prioritization of the needs (by June 2004).

This document is meant to serve as a brief overview of the processes involved. More comprehensive documentation will be made available for the individual steps.

First Step: Identification of Needs

The first step of the process is to identify the health needs in Washington State of the MCH populations. Traditionally, needs assessments focus on the base or indicator level. Indicators (i.e. infant mortality, percent of population who smokes, etc) will still be used to justify and monitor the effectiveness of the strategies employed. This process, however, attempts to take a higher level approach. For the purpose of this process, **needs are defined as those strategies [needed] to improve the health status of the MCH population(s) identified**. Following is an overview of the process to identify the needs of the MCH populations.

What do we need to do to create/have a healthy "____" (insert term of choice: infant, pregnant woman, child, teen, etc.) population in Washington State?

- What does a healthy "____" look like?
- What do we know about "____" in Washington?
- What do we need to do to promote healthy "____"? What are we already doing and what still needs to be addressed?
- What kinds of strategies or goals if accomplished would promote healthy "____"?

In addition, the following question helps assess the capacity to address the identified needs/strategies. (Second Step)

- What is Washington's ability to do this work? What is the DOH role in this work?

EXAMPLE:

- What does a healthy pregnant woman look like?
  - Healthy, safe…….
- What do we know about pregnant and reproductive age women in WA?
  - Explore data on lbw, preterm delivery, smoking in pregnancy, etc.
  - Look at disparities by geography, race/ethnicity, urban/rural, age, women w/special needs, SES, etc.
- What do we need to do to promote healthy pregnancies?

- Smoke free, prenatal care, Social support systems, Adequate Nutrition, Etc.

- What kinds of strategies or goals if accomplished would promote healthy pregnancies? Identify what we are already doing and what still needs to be addressed:
  - Prenatal care:
  - Health insurance for all pregnant women; adequate number of providers, etc.
- What is Washington's ability as a state to do this work? What is the DOH role in this? Identify capacity to address both current and new strategies.
  - Health insurance:
  - Eligibility, benefits, etc.

Outcome of First Step:

At the end of this process, you should have identified a list of needs, i.e., strategies [needed] to improve the health status of the MCH population(s) identified. These needs may include both strategies already being undertaken by DOH as well as newly identified strategies.

Considerations as the Process to Identify Needs is Developed:

There are two key components to keep in mind: use of stakeholders and the process must be data driven. Both components are critical. Following is some additional detail to help the process.

Stakeholders:

- External stakeholders
- Consumers: Remember it is important to include consumers as stakeholders when possible. In the 2000 Needs Assessment we were criticized for not incorporating consumers in more parts of our process (we included consumers as part of CSHCN and the overall prioritization retreat but not with MIH, nor CAH).
- Internal stakeholders- Gain input from OMCH staff and keep them informed, involved in the process.

Data Driven:

⇨ The identification of needs/ issues for the Five Year Needs Assessment should be based on data, when available, and should ultimately take into account the size and seriousness of a problem.

⇨ Use common indicators and existing reports as a basis for identifying data driven issues. A draft list of indicators for Washington's Five Year Needs Assessment is available as an Excel spreadsheet on the p drive at: Common/Five Year Needs 2005/Naindicators.xls

Existing Data/ Reports:

- Health of Washington State 2002 (http://www.doh.wa.gov/HWS/default.htm)
- PRAMS Reports (http://www.doh.wa.gov/Publicat/publications.htm#H)
- Perinatal Indicators Report (p:/common/mchdata/Key Indicators of Perinatal Health)
- Healthy Youth Survey Reports (http://www3.doh.wa.gov/HYS/)
- Injury Data available at: http://www.doh.wa.gov/cfh/Injury/Tables_update.htm

- Birth and Death data available at: http://www.doh.wa.gov/EHSPHL/CHS/CHS-Data/main.htm
- Children with Special Health care needs data: Contact Stacey De Fries

Forthcoming Reports:

- MCH Data Report ~December 2003
- MCH Rural Health Monographs_ December 2003
- Child Injury Report~ February 2004
- Birth Defects Registry Report ~December 2003
- Children with Special Health Care Needs ~Summer 2004

⇨ Identify additional indicators you may want to use (you want to use indicators that have been validated and used elsewhere). Here are some sources for potential indicators to identify needs/ issues:

- MCHB Model Indicators: List of indicators and data sources that are MCH-specific:http://www.uic.edu/sph/dataspeak/dataspeak1/model%20indicator%20report.htm
- Healthy People 2010: Includes indicators for a variety of condition and population-specific domains. Has a section specific to maternal, child and infant health: http://www.healthypeople.gov/Document/tableofcontents.htm#under

⇨ Identify what more data/ information you need from MCH Assessment to help you prioritize needs.

This process will often include discussions on the political and economic feasibility of conducting strategies to address health issues. Although this is appropriate to include in the discussions, the ranking of priorities should be conducted during the third step of the process.

In order to assess the health of the population, you will need to include the SIZE and SERIOUSNESS in the discussions.

Size: The size of the problem refers to the percent of the population affected. This may be obtained from the incidence/prevalence of a health issue. In assessing the size of the problem, you may also want to consider the size of the problem across various sub-populations, and whether disparities exist. It can be helpful to look both at the percent or rate of the adverse outcome in the population as well as the absolute number of people affected. For example, a rate may be quite high, but if the population is small, the number of people affected may not be all that large. In the 2000 Needs Assessment, the Assessment Unit scored health issues and provided a rating as follows and used the overall MCH population to determine the rating. High rates among subpopulations or other disparities was used to "bump" the score up slightly:

Percent of Population Affected	**Rating**
25% or more	9-10
10%-24.9%	7-8
1.0%-9.9%	5-6
0.1%-0.9%	3-4
0.01%-0.09%	1-2
Less Than 0.01% (1/10,000)	0

Seriousness: In rating the seriousness of the health issues, several factors should be considered, including the death rate and illness/hospitalization rate associated with the health issues and the emergent nature of the health issues. Answering the following questions may help you determine the health issue's seriousness.

- Does the health issue have a high death and/or hospitalization rate?
- What are the consequences of the health issue in terms of disability, other health problems, and communicability?
- Is the health issue worsening over time, improving, or staying the same?
- Does this health issue require an immediate public health response? What would the nature of that response be?
- Is there an economic impact associated with this health issue?
- Does this health issue have long term implications for the health of the individual or family?
- How does the health issue in Washington compare to the United States as a whole?

Recommended ratings are:

Seriousness of Health Issue	Rating
Very Serious	8-10
Serious	5-7
Moderately Serious	2-4
Not Serious	0-1

Second Step : Assess the capacity of the MCH health services system in Washington

Before moving on to prioritizing needs, it is helpful to qualitatively assess with your stakeholders the state and local capacity for addressing MCH health in Washington. In doing this, you may be able to determine if any additional needs or strategies should be added to your identified needs. We have developed three criteria to help you review and assess the current capacity within Washington to promote the health of the population through direct and enabling services: availability, affordability and accessibility of services. These criteria are described briefly below:

Availability - Availability refers to whether there are sufficient medical providers, clinics and/or hospitals to meet the health care need. Further, does the geographic distribution of these providers and clinics meet the demand? Are there concerns statewide or locally about the availability of specific providers, clinics, or services to meet a group of health care needs (eg prenatal care) or a specific health care need (eg nutritional counseling for children with oral clefts).

Affordability – Affordability refers to whether sufficient public and private insurance coverage exists to meet the health care needs of the MCH population. Are insurance plans available, affordable (premiums, deductibles, and copays), and comprehensive with respect to covered services? Is Medicaid or Basic Health available for those who can't afford private insurance? Do providers accept Medicaid and Basic Health patients?

Accessibility – Accessibility refers to whether the population can adequately use the available services, and whether they are using the available services. Are there any barriers with respect to: geography or transportation to services, appointment or clinic hours, wait times for appointments, accessibility for people with disabilities, translation and cultural competency, provider networks and referral to specialty providers, and continuity of care? Does the population know about the services available and how to obtain these services?

Assessing the capacity to address population-based and infrastructure services to promote the health of the population is less clear. It may be helpful to review the needs (strategies) identified, and for each strategy ask a series of questions:

- What is Washington's ability to do this work?
- What is the DOH role in this work?
- If DOH is already engaged in this work, are we successful at it? What do we need to be successful, or to continue to be successful?
- If DOH is not engaged in this work, why isn't DOH doing this? What would it take (fiscal and staff resources) for DOH to take on this role? Does that seem feasible?

Outcome of Second Step:

At the end of this process, you may have added some identified needs (strategies) to the list that was generated during the First Step. In addition, you should now have a sense of the state overall and DOH's capacity to take on these identified needs/strategies. You may choose to develop a capacity score for each identified need or to keep some other written documentation of the assessed capacity. .

Final Step: Prioritizing the needs of your population

At this step, the sections combine the results of their identified needs and capacity assessment to produce a list of the top ten identified needs.

In this step, you may want to consider the criteria already mentioned, including size, seriousness, state capacity, DOH capacity, as well as additional criteria not yet mentioned. These may include: a) the effectiveness of known interventions, b) the economic impact of not addressing the problem in the next five years, c) whether the intervention is acceptable to the community or to stakeholders, or other criteria your staff or stakeholders suggest.

Once you have decided on criteria for prioritization, you need to determine the process you wish to use for prioritizing the identified needs. This can be a formal scoring process or an informal review. A formal scoring process might look like the following. Each identified need could be given a rating for each criterion. The ratings could then be summed or combined in another fashion to come up with an overall score. Once the scores are completed, they can be used to rank the scores. An informal review might entail asking participants to consider the criteria before ranking the identified needs.

To gather input from all stakeholders, stakeholders can be asked for their top 3 (or 5 or whatever number) priorities based on the ranking mentioned above or an informal review. Once stakeholders

have identified their top priorities, the needs can be ranked by the number of "votes" they have. The group can then discuss the ranking, whether it fits with their sense of the criteria, and holds validity for them as the priorities.

Outcomes of Final Step:

At the end of this process, you should have identified a 10 priority needs, i.e., strategies [needed] to improve the health status of the MCH population(s) identified. These needs may include both strategies already being undertaken by DOH as well as newly identified strategies. These 10 priorities will be combined with the priority needs of the other MCH populations for the Fall 2004 prioritization meeting.

The process by which you have arrived at this list of priority needs also needs to be documented and written up in a concise format by the end of the process. This write up will be used in the MCH Block Grant submission of the Five Year Needs Assessment. It would be helpful to include any meetings held, stakeholders (ie, constituencies represented) involved, data sources consulted, and questions asked, etc. Careful documentation will also help us evaluate both the process and the outcomes once we have completed all of the 2005 Five Year Needs Assessment.

Appendix C: Letter to Public health Nursing Directors with stakeholder surveys

April 14, 2004

TO: Public Health Nursing Directors

FROM: Jan Fleming, Director Office of Maternal and Child Health

SUBJECT: Establishing Priorities for the MCH Populations

The Washington State Department of Health, Office of Maternal and Child Health (OMCH) is currently engaged in the Five Year Needs Assessment as required for our Title V funding from the Health Resources and Services Administration. As part of this Needs Assessment, we must identify 10 priorities to guide OMCH work from 2005 to 2010. We are contacting you as one of our stakeholders to help determine these priorities.

Attached are three lists of draft priorities for the MCH subpopulations: the pregnant women and women of childbearing age population, the infant population, and the school age child population (6-18 years). Issues related to Children with Special Health Care Needs have been incorporated into each of these populations.

Based on your knowledge right now, please review the list for each subpopulation and:

1) List any issues you feel are priorities in Washington that are not represented on this list.

2) From among this list, tell us what you feel are the top 10 priorities in Washington for this subpopulation.

3) List any additional comments you would like us to consider

You may want to consider the size or prevalence of the issue, the seriousness/health consequences of the issue, and the effectiveness of known interventions in your assessment of these draft priorities. See attached definitions for more detail.

We will take your response along with those of other stakeholders and consider them later this spring when workgroups within OMCH review the draft priorities to determine 10-15 final priorities for each subpopulation. Our plan is to review the priorities identified by the subpopulation workgroups together during a retreat with stakeholders in Fall 2004 to identify 10-15 MCH priorities for the Five Year Needs Assessment. At that time, in addition to considering the size, seriousness, and intervention effectiveness, we will also consider factors such as the economic impact of not addressing the issue, whether the Department of Health (DOH) is the appropriate agency to address the issue, whether DOH has the legal authority to address the issue, whether there are acceptable interventions for the issue, and

whether resources are available or can be leveraged to address the issue. In preparation for this retreat, issue papers will be developed for each of the approximately 40 priorities identified by the subpopulation workgroups. We will be contacting you to identify Nursing Directors who would like to participate in the Fall prioritization retreat.

Please send your response to Vicki Bouvier (vicki.bouvier@doh.wa.gov) by April 30th. If you have any questions about the Five Year Needs Assessment Process or would like additional information about the Needs Assessment, please contact Vicki at the above email.

Thank you for your participation. We greatly value your time and input and look forward to hearing from you.

MCH Needs Assessment Priorities: Infants

The following is an initial list of suggested priority areas for your consideration. This is not a comprehensive list. It was developed based on a review of previous priorities and input from stakeholders. It represents a starting point in the process to determine final priorities for the MCH population for the next 5 years. Feel free to add any priorities that are missing.

Choose your top ten priorities from those listed and any that you added, using the criteria provided. Please return this document **by April 30th** to Vicki Bouvier at Vicki.bouvier@doh.wa.gov

Infant: Long term outcome is a healthy infant

Priority	**Priority Number 1-10 (1= highest)**	**Comments**
Decrease Low Birth weight (LBW) and Very Low Birth weight (VLBW) rates, with a special focus on African American, Native American, and Medicaid families	1	
Decrease Infant Mortality (IM), with a focus on African American and Native American population	2	
Improve early identification and diagnosis of chronic health conditions ▪ *Includes: Increase the number of hospitals screening infants for hearing; Increase newborns screened for metabolic disorders and conditions confirmed*	8	
Promote intervention and coordination of services for chronic health conditions ▪ *Includes: Increase the number of infants, with abnormal hearing screens, who are referred for diagnostic services performed by a qualified and educated audiologist by 3 months of age; Increase the number of infants, with hearing loss, that are enrolled in early intervention services by 6 months of age; Increase the services available for infants that are deaf/hard of hearing (D/HH).*	10	
Decrease family violence ▪ *Includes: Domestic violence; Child abuse and neglect; Molestation*	3	
Improve nutrition ▪ *Includes: Increase food security; Decrease hunger; Establish and maintain an appropriate pattern of growth*	5	

Improve rates of breastfeeding initiation and duration	9	
Increase percent of families who partner in decision making related to care		
Increase medical insurance coverage for all infants	4	
Increase number of infants who have had recommended immunizations in first year of life	6	
Increase rate of VLBW infants delivering in facilities with tertiary level nursery services		
Decrease infant exposure to second hand smoke	7	
Others (Please specify)		

MCH Needs Assessment Priorities: Pregnant and Non-pregnant women of CBA (Child bearing age)

The following is an initial list of suggested priority areas for your consideration. This is not a comprehensive list. It was developed based on a review of previous priorities and input from stakeholders. It represents a starting point in the process to determine final priorities for the MCH population for the next 5 years. Feel free to add any priorities that are missing.

Choose your top ten priorities from those listed and any that you added, using the criteria provided. Please return this document **by April 30th** to Vicki Bouvier at Vicki.bouvier@doh.wa.gov

Pregnant and Non-pregnant women of CBA (Child bearing age):

Long term outcome is: healthy pregnant women and healthy woman of CBA

Priority	**Priority Number 1-10 (1= highest)**	**Comments**
Decrease unintended pregnancy (UP)	1	
Improve access and early entry to prenatal care (PNC) and delivery		
Promote comprehensive prenatal care ▪ *Includes: screening for medical and behavioral risks that impact a healthy pregnancy; ensuring that all women of 14 weeks gestation or more get a flu shot during influenza season; evaluation and evaluation of available obstetrical genetic services*	4	
Prevent smoking initiation in young women and decrease tobacco use among those who already smoke.	7	
Improve access to mental health services	8	
Promote effective substance abuse programs and services	2	
Decrease family violence ▪ *Includes: Child abuse; Domestic violence; Sexual assault*	3	
Improve nutritional status in women of childbearing age ▪ *Includes: Adequate weight gain in pregnancy; Reduce morbid obesity; Reduce hunger*		
Increase diagnosis and management of medical conditions early in pregnancy and prior to pregnancy	9	
Increase rate of pregnant women and		

women of CBA who receive counseling from health care provider on tests for identification of birth defects or genetics diseases		
Increase oral health insurance coverage and access to services	5	
Promote healthy lifestyle prior to pregnancy ▪ *Includes: Healthy weight; Increased physical activity; No drug or tobacco use; No violence Identified and managed diseases; Healthy mental and emotional state; Pregnancy planning and adequate spacing; Environmental exposure; Folic acid intake*	6	
Decrease teen pregnancy		
Increase primary care providers' knowledge of genetics and awareness of clinical and laboratory genetic services for across the lifespan		
Increase the number of highly qualified genetics providers.		
Increase the public's awareness regarding genetics.		
Eliminate/minimize health disparities, particularly for individuals with disabilities, by: ▪ *making MCH programs applicable to persons with disabilities (who may value or define "health" differently)* ▪ *providing alternate formats of MCH health promotion materials, using "people-first" language* ▪ *providing culturally sensitive interventions*	10	
Others (Please Specify)		

MCH Needs Assessment Priorities: Middle Childhood, Adolescents

The following is an initial list of suggested priority areas for your consideration. This is not a comprehensive list. It was developed based on a review of previous priorities and input from stakeholders. It represents a starting point in the process to determine final priorities for the MCH population for the next 5 years. Feel free to add any priorities that are missing.

Choose your top ten priorities from those listed and any that you added, using the criteria provided. Please return this document **by April 30th** to Vicki Bouvier at Vicki.bouvier@doh.wa.gov

Middle Childhood/ Adolescents: Long term outcome is: healthy youth and adolescents

Priority	**Priority Number 1-10 (1= highest)**	**Comments**
Promote physical, social and emotional growth and development	1	
Reduce/ Prevent Depression and other mental health disorders	9	
Teen pregnancy prevention and parenting		
Reduce/ Prevent Sexually transmitted infections ▪ **Includes: Chlamydia, gonorrhea, HIV…**	8	
Reduce/ Prevent Illicit Drug Use ▪ *Includes: Methamphetamine, ecstasy, marijuana*		
Reduce/ Prevent Alcohol Use ▪ **Includes: Binge drinking/Early initiation**	3	
Reduce/ Prevent Tobacco use ▪ **Includes: Smoke/smokeless**	2	
Promote Adequate Nutrition		
Promote Physical activity		
Reduce/ Prevent Overweight/obesity		
Reduce/ Prevent Intentional injury: ▪ *Includes: Suicide, Homicide, Weapon carrying/ bullying/ harassment, Partner/dating violence, Child maltreatment*	5	
Reduce/ Prevent Unintentional injury	4	

▪ *Includes: Motor vehicle crashes, Drunk driving, Helmet use/seatbelt use, Drowning*		
Improve Oral health		
Promote a Healthy Environment Includes: Asthma, lead, asbestos, fluoridation		
Promote School achievement ▪ *Includes: Learning disability, Graduation/drop out, School-to-work/ School-to-college*		
Promote Youth with special health care needs and disabilities in transition		
Improve Health care access ▪ *Includes: General health/specialty services/ reproductive/ mental health/ oral health*	6	
Focus on Special populations ▪ *Includes: Homeless youth, Migrant workers, Undocumented immigrants, Gay/lesbian/bisexual/transgender*		
Reduce/ Prevent Health disparities		
Promote Immunizations	10	
Reduce/ Prevent Chronic Diseases	7	
Others (Please Specify)		

Appendix D: Examples of one logic model

HIGH QUALITY PRENATAL CARE (including Intrapartum and Newborn care) For Pregnant/ Non Pregnant Women

Inputs or Resources	Activities	Outputs	Short-term Outcomes *(Focus: Knowledge /Awareness)*	Intermediate Outcomes *(Focus: Action/ Behavior Change)*	Long-Term Outcomes or Goals
DOH Staff: MIH 1.9FTE **GENETICS** GSS, some of Deb, Angie and Amber **Funding** MIH staff $133,000 MIH contracts $17,000 Perinatal contracts $743,000 MAA FS direct service budget MAA Medical direct svc budget HRSA Genetics Implementation Grant MCHBG Title XIX Partners: **Genetic Advisory**	**CURRENT** ASSESSMENT: 1. Gather data on quality of care through such surveys as BRFSS, PRAMS and analysis of other available data such as birth certificate data. 2. Participate on the PRAMS planning committee and administer PRAMS survey. 3. Monitor progress towards goals and objectives. **ASSURANCE** 4. Provide First Steps MSS services – screening, referral, and interventions- to promote quality care for low-income pregnant women. 5. Contract with tertiary level perinatal referral centers to provide regionalized services for pregnant women and newborns statewide[i] 6. Disseminate CDC Group B Strep (GBS) best practice materials to providers. 7. Convene the Perinatal Advisory Committee to identify and prioritize statewide perinatal concerns; identify need, produce materials as needed, and make recommendations through specific work groups to address perinatal issues; provide consultation and recommend prioritized solutions to	Physician Focus groups report Living Room Forum transcripts, report, newspaper articles, website GAC/GPG meeting minutes ~6000 providers receive MOD pocket facts on genetic screening ~3000 providers receive information on CF screening recommendations #providers/#consumers that receive teratogen information #cytogenetic studies and GC for women (per year) that wouldn't be able to afford Genetics services evaluation report	Activities 1-3: ▪ Improved recognition and surveillance of risk behaviors among women and women of CBA. Activity 4: ▪ Low income pregnant women get nutritional education and breastfeeding education and support; monitor weight gain; screening for substances and violence; infant care and parenting education and support; tobacco and second hand smoke intervention Activity 5: ▪ Appropriate high risk pregnancy management, monitor vlbw delivery rates; advocate for delivery of vlbw infants at high risk facilities Activity 6: ▪ Providers screen appropriately for GBS and provide correct meds during labor for GBS+ women. Activity 7:	Activities 1-3: ▪ Improved identification of risk and protective factors to identify high-risk women and communities to better address their needs. ▪ Use of current and readily available data for program planning, implementation and evaluation Activity 4: ▪ Increase number of women gaining appropriate weight during pregnancy and number who breastfeed; improved infant care; reduced number of infants exposed to second hand smoke Activity 5: ▪ Improved high risk pregnancy management and VLBW infants born in high risk facilities Activity 6: ▪ Infants do not get infected with GBS Activity 7: ▪ Emerging perinatal issues addressed Activity 8?: ▪ Improved outcomes: also see 1,3,4,5 above Activity 10: ▪ Early identification and successful management of medical conditions (HTN, DM etc.) ▪ Increased numbers of pregnant women get screening and referred. Activity 11-12: ▪ More women get an HIV test during pregnancy and HIV+ women get appropriate medication	**High quality prenatal care** INDICATORS: ❑ Increased # of Pregnant women who report HC provider discussed important pregnancy health behaviors: ***Increased % of pregnant women who state that a prenatal HC provider talked to them about negative impact of smoking on their baby*** Overall: 81.2% Medicaid: 87.3% Non-Medicaid: 77.4% ***Increase in Women who reported a prenatal HC provider discussed what foods should be eaten during pregnancy:*** Overall: 89.4% Medicaid: 91.4% Non-Medicaid: 88.1%

Committee **Genetic providers** **Publicis Dialog** **Health care providers** **First Steps providers** PAC Reg Perinatal Programs WSOA WA –ACOG DSHS DOH-Tobacco DOH- HIV DOH- HSQA	the Department of Health and DSHS (Medicaid)[ii] 8. Work with Physicians Insurance to revise the Uniform Prenatal Medical record to improve screening and documentation of critical issues related to content of prenatal care (GBS, HIV, DV etc.) [iii] 9. Develop and disseminate to all families of children ages 0-6 CHILD Profile messages and women's health flyer on health, growth, development, and safety. 10. Provide substance abuse (including tobacco) and violence best practice tools and materials and referral resource information to providers. 11. Inform providers about prenatal HIV testing WAC and provide HIV testing and management best practice materials to ob providers. 12. Work with HSQA-hospital surveyors to promote HIV rapid testing in labor and delivery. 13. Advocate for appropriate immunization during pregnancy. 14. Educate providers on genetics via: mailings, focus groups (assessment), including informing providers on standards of care. 15. Provide support to Care NW for a hotline for providers and consumers on teratology issues (Teris subscription). 16. Provide instruction at Seattle Midwifery on genetics, teratogens, NBS and embryology 17. Provide support to Regional Genetic Clinics (which do testing, diagnosis and evaluation). 18. Assess feasibility of telemedicine.[iv] 19. Increase awareness of genetics	Articles, references and resources and other best practice materials on various issues are disseminated CDC guidelines on rapid HIV testing in labor and delivery Immunization recommendations for pregnant women Contract with Regional Perinatal Programs Professional education, consultation and transport services to ob providers and hospitals CDC GBS materials Updated Uniform PN Medical record Proposed: Set of QI indicators	▪ Identify and prioritize statewide perinatal concerns; make recommendations to address perinatal issues Activity 8? ▪ Increase appropriate screening, management and documentation Activities 10: ▪ Increased number of providers screen for alcohol drug, tobacco use and violence during pregnancy Activity 11-12: ▪ Increase testing for HIV and use of meds ▪ Hospital surveyors include information and recommend development of rapid HIV testing protocol Activities 14-18: ▪ Increase primary care provider knowledge of genetics and awareness of clinical lab genetics services ▪ Increase early dx and management of medical conditions **I**ncrease number of highly qualified genetics providers Activity 19: ▪ Ensure appropriate policy development **Proposed:** Target activities to improving areas identified	▪ Hospitals develop policy for HIV rapid testing Activity 13: ▪ Ob providers immunize pregnant women ▪ Women of 14 weeks gestation or more get a flu shot during influenza season Activities 14-18: ▪ Increase rate of pregnant women who receive counseling from HCPs on tests for ID of birth defects or genetic diseases and rate of testing. ▪ Increase the number of pregnant women who are appropriately referred for genetic counseling. Early dx and management of genetic conditions. ▪ Activity 19: ▪ Informed laws and policies related to the MCH population. **Proposed:** 1. Improved quality of PNC WHY: ❑ Pg women may be at increased risk for serious medical complications of influenza ❑ Risk of hospitalization for influenza-related complications was more than 4x higher for women in the 2nd or 3rd trimester compared to non-pregnant women. ❑ CDC ACIP recommends flu vaccination for women in the 14th week or more of gestation during flu season (Ros – think this changes – MMWR in Apr or May will recommend vaccine at any point during pregnancy during flu season) ❑ PNC reduces LBW, IM ❑ Comprehensive care more likely to address: screening and intervention: violence, substance abuse, tobacco, medical conditions, prenatal testing, HIV testing ❑ HWS pg 264, 270 ❑ MDS shows that the number of women having amniocentesis for diagnosis of chromosomal anomalies has been decreasing ❑ GAC/laboratory data shows that the number of babies	***Increase # of Women who report hc provider discussed breast feeding baby:*** Overall: 87.4% Medicaid: 92.6% Non-Medicaid: 84.2% ***Increased # of women who report hc provider discussed alcohol:*** Overall: 80.5% Medicaid: 84.9% Non-Medicaid: 77.7% ***Increase # of women who report hc provider discussed Physical abuse:*** **Overall: 61.6%** **Medicaid: 51.1%** **Non-Medicaid: 30.6%** ***Increase # of women who report provider discussed diseases or birth defects that run in the family:*** **Overall: 79.8%** **Medicaid: 78.1%** **Non-Medicaid: 80.9%**

	issues: Hold Living Room Forums to assess the attitudes, knowledge and understanding of genetics issues by the general public and use information gained to further disseminate genetics awareness among the general population.[v]. 20. Promote appropriate use of prenatal diagnosis and genetic counseling by providing funding for state match of Medicaid funding for prenatal dx/ genetic counseling. 21. Evaluate access and availability of OB genetic services (through surveys of OB providers and clinics providing genetic services) 22. Promote collaboration among Genetic Health Services providers and stakeholders through community education and networking (Genetic Providers Group meetings and state Genetic Advisory Committee) **POLICY:** 23. Monitor legislation and promote policies that work to promote quality care of pregnant women and women of CBA. Proposed: 24. Develop set of QI indicators to measure prenatal care content			that are prenatally diagnosed with Down syndrome and other chromosome anomalies has decreased, while the incidence has not ❑ WNATS showed that much of the public is not aware of, nor utilizes, prenatal/preconception genetic services ❑ After the CF mailing on ACOG/ACMG recommendation, many physicians called our office seeking more information about the CF screening ❑ The OB survey will provide data on what services are currently being offered and/or referred for patients ❑ HWS pg 263 HTN and DM associated with LBW ❑ HWS pg 269: associated with IM 1999: 58% cases of IM were where pregnant women had one or more medical condition ❑ Adequate weight gain during pregnancy prevents LBW and thus IM, HWS pg 269 ❑ Morbid obesity associated with increased HTN, DM and macrosomia (lge baby) ❑ Obesity related to increased risk of GDM assoc with perinatal complications; women and offspring at increased risk of developing DM later. OB and GYN March 2004 p 526; maternal morbid obesity and increased risk of adverse pregnancy outcome – Ob and GYN Feb. 2004 pg 219	***Women who report HC provider discussing <u>genetic testing</u>:*** **Overall: 90.4%** **Medicaid: 86.3%** **Non-Medicaid: 93.0%** ***Women who report HC provider discussed HIV testing:*** **Overall: 85.2%** **Medicaid: 87.7%** **Non-Medicaid: 83.5%** ❑ <u>Improved postpartum health behaviors</u>

Prenatal Care Services

Comprehensive, quality prenatal care helps to improve birth outcomes by identifying medically and socially high risk women early in their pregnancies in order to monitor their health status, provide timely interventions and refer them to support services. In 1999, 82.9% of women delivering live births received prenatal care during the first trimester, compared to 83.0% in 1998. Disparities in accessing first trimester prenatal care exist. Women younger than age twenty and minorities have the lowest proportions of accessing first trimester prenatal care. In 1999, 68.2% of women less than age twenty, and 71.2% of American Indians, 71.1% of Hispanics, and 75.5% of Blacks in Washington accessed first trimester prenatal care. Similarly, Washington women on Medicaid continue to lag behind with only 70.6% of women receiving early prenatal care, despite substantial improvement since First Steps began in 1989. Based on the 1997-1999 data, Washington State counties classified as suburban had significantly higher rates (77.8%) of first trimester prenatal care compared with counties classified as urban core (74.9%), large town (74.9%), and small town / isolated rural (74.1%).

/2003/ In 2000, 82.6% of Washington women giving birth had prenatal care in the first trimester. First trimester PNC remains lowest in Native Americans (72.7%), Hispanics (71.0%), and Blacks (74.5%). Teens continue to have the lowest rates of first trimester prenatal care compared to other age groups.

/2004/: / In 2001, 83.2% of Washington women giving birth had prenatal care in the first trimester. While this represents a significant increase from the 1990 proportion of 77.6%, the proportion of women with a live birth obtaining first trimester prenatal care has not significantly changed since 1994. First trimester PNC remains lowest in Native Americans (72.1%), Hispanics (73.2%), and Blacks (76.9%). Teens continue to have the lowest rates of first trimester prenatal care compared to other age groups (69.4%). 3.0% of Washington women had late or no prenatal care, with the highest proportions in Native Americans (6.9%), and Hispanics (5.3%).

From 1999-2001, women with a live birth who lived in urban counties were significantly more likely to enter into prenatal care in the first trimester compared to pregnant women from nonurban counties.

RUCA Codes for First Trimester PNC, 1999-2001

	% First Trimester PNC	95% CI	+95% CI
Urban	83.8	83.61	83.98
Large Town	83.4	82.99	83.86
Mixed Rural	79.5	78.99	80.04
Small town/ rural	77.5	76.87	78.18

(Overall Missing/ Unknown =8.5%)

In 1999, 70.4% of Washington women received adequate or better prenatal care, based on the Kotelchuck Index of Prenatal Care Adequacy. This rate has decreased slightly since 1990 when 71.5% received adequate prenatal care. In 1999, 11.1% of Washington women received inadequate prenatal care, representing a 23% decrease

since 1990. Non-Whites, Hispanics, and teens had the highest rates of inadequate prenatal care in 1999. The Healthy People 2010 objective is to increase the proportion of pregnant women who receive early and adequate prenatal care to 90%.

/2003/ In 2000, 70.6% of Washington women giving birth has adequate prenatal care, while 12.0% received inadequate prenatal care based on the Kotelchuck index. Teens, non-Whites and Hispanics had the highest rates of inadequate prenatal care in 2000. (HSI C3)

/2004/: In 2001, 70.2% of Washington women giving birth had adequate prenatal care, while 11.5% received inadequate prenatal care based on the Kotelchuck index. Disparities persist. Nonwhites have significantly higher rates of inadequate prenatal care compared to Whites, with Native Americans (20%) and Blacks (18%) having the highest proportion. Hispanics (19%) are more likely than nonHispanics (10%) to receive inadequate prenatal care. Twenty-two percent of teens in 2001 received inadequate prenatal care compared to 12% of women in their twenties, 8% of women in their thirties, and 10% of women in their forties.

PRAMS data provide some information on the barriers to prenatal care as well as on the quality of prenatal care through reports of issues discussed during prenatal care visits. In 1999, over 80% of respondents reported discussing medication safety, nutrition, breastfeeding, family history of disease, prenatal testing, early labor, alcohol/drug use in pregnancy, and postpartum contraception. Fewer respondents reported discussing physical abuse, HIV testing and prevention, seat belt use or postpartum depression with their providers.

Overall, 78.3% of the PRAMS respondents in 1999 stated they received prenatal care as early as they wanted, while 21.2% stated they did not, and 0.5% stated they wanted no prenatal care. PRAMS also offers insight to the reasons women fail to access first trimester prenatal care. Reasons cited by PRAMS respondents when asked why they did not get prenatal care in their first trimester include:

- Couldn't get an earlier appointment (35%)
- Had no money (34%)
- Didn’t know was pregnant (22%)
- Too busy (11%)
- No transportation (6%)
- No MD/RN (3%)
- No Childcare (2%)

/2003/ In 2000, 80.5 %(± 2.7%). of the PRAMS respondents stated they received prenatal care as early as they wanted, while 18.7%(± 2.7%) stated they did not, and 0.8%(± 0.6%) stated they wanted no prenatal care. The most common reasons stated for not getting prenatal care as early as wanted were similar to last years: did not know was pregnant (30%), could not get an appointment (29%), or did not have enough money or insurance to pay for visit (22%).

/2004/No new data are available.

Low Birth Weight

In 1999, there were 4,632 low birth weight (LBW) infants (birth weight less than 2500 grams) born to Washington residents, a LBW rate of 5.9%. Of these, 801 infants were born very low birth weight (VLBW or birth weight less than 1500 grams), a rate of 1.0%. Review of data for the past 10 years reveals a 13.1% increase in LBW rates since the lowest percent reached in 1991, and an 18.2% increase in VLBW rates. Increasing LBW rates have also been reported nationally. Washington State

Black experienced the highest rate (10.7%) in 1999, followed by Asians (7.1%) and American Indians (6.4%). From 1997-1999, the proportion of low birth weight births in Washington was significantly higher for residents in urban core areas (5.9%) compared with suburban areas (5.0%), or large town areas (5.3%), and small town / isolated rural areas (5.3%).

/2003/ In 2000, there were 4,517 LBW infants born in Washington state, representing 5.6% of live births. A total of 773 infants were born VLBW. LBW rates continue to be highest in black infants (10.8%), followed by Native Americans (6.7%) and Asian/Pacific Islanders (6.2%). VLBW rates are also highest in black infants (2.6%). LBW rates are highest in teens and mothers over age 40. From 1998-2000, the proportion of low birth weight births in Washington continued to be significantly higher for residents in urban core areas (6.0%) compared with suburban areas (5.0%), large town areas (5.3%). The LBW rate for small town / isolated rural areas (5.5%) was higher but not significantly different from the suburban and large town areas. According to data from the First Steps database, Medicaid women were significantly more likely (6.4%, 95% CI 6.1-6.6%) than non-Medicaid women (5.0%, 95% CI 4.8-5.2) to have a LBW baby.[1]

/2004/: In 2001, there were 4,588 LBW infants born in Washington state, representing 5.8% of live births. This represents a significant increase from 1990, when 5.3% of Washington births were LBW. A total of 825 infants were born VLBW (1.04% of births) in 2000, which is significantly higher than the 1990 proportion of 0.83%. LBW rates continue to be highest in black infants (9.9%), followed by Native Americans (8.3%) and Asian/Pacific Islanders (6.0%). VLBW rates are also highest in black infants and Native American infants (1.9%). LBW rates are highest in teens and mothers over age 40 (8.8%).

According to birth certificate data from 1999 through 2001, large town areas had the smallest proportion of LBW births..

RUCA Codes for Low Birthweight, 1999-2001

	% LBW	95% CI	+95% CI
Urban	6.0	5.85	6.08
Large Town	5.1	4.84	5.34
Mixed Rural	5.2	4.93	5.50
Small town/ rural	5.6	5.25	5.96

(Overall Missing/ Unknown =0.7%)

According to data from the First Steps database, 6.3% of Medicaid women had a LBW baby compared to 5.3% of NonMedicaid women.

Because multiple births are often LBW and the incidence of multiple births has been increasing, the rate of singleton LBW has been used to determine whether the increase in LBW is independent of the increase in multiple births. Washington data indicate singleton LBW rates have also increased slightly since the early 1990's. In 1999, 4.5% of singleton births were LBW, and 0.8% were VLBW. One of the goals of the MCH program has been to ensure that VLBW infants are born at or transferred to subspecialty facilities with appropriate staffing, resources, and experience for their care. In 1999, 73.9% of VLBW resident births that occurred in Washington were delivered at subspecialty care facilities, down from 80.7% in 1998. This change does not appear to be due to more VLBW deliveries at any single hospital, but to increases at several hospitals including both primary care and specialty care facilities. Of note, while the VLBW rate did not increase in the last year, the proportion of infants below 500 grams doubled, which may be contributing to the shift in delivery facilities. Related Healthy People 2010 objectives are to reduce LBW deliveries to no more than 5% of live births and VLBW deliveries to no more than 0.9% of live births. (Pri. 1, NPM15, NPM 17)

[1] Data provided from First Steps Database, DSHS Research and Data Analysis, March 2002.

/2003/ In 2000, 4.4% of Washington singleton births were LBW, while 0.8% were VLBW. In 2000, 67.4% (±3.3%) of VLBW resident births that occurred in Washington were delivered at subspecialty care facilities. The CY2000 target for this objective was 79.4%.

/2004/: / In 2001, 4.5% of Washington singleton births were LBW, while 0.8% were VLBW. In 2001 75.4% of VLBW resident births that occurred in Washington were delivered at subspecialty care facilities. The CY2001 target for this objective was 79.6%.

Pregnancy-Associated and Pregnancy-Related Mortality

Recently, OMCH has been evaluating methods for improving surveillance of pregnancy-associated and pregnancy-related mortality in collaboration with perinatologists from the UW and Southwest Washington Perinatal Services. Pregnancy-associated mortality includes all deaths while a woman is pregnant or within one year of pregnancy regardless of the cause of death or site of pregnancy. Pregnancy-related mortality is a subset of pregnancy-associated mortality and includes all deaths while a woman is pregnant or within one year of pregnancy that are caused by the pregnancy or by a condition that is exacerbated by pregnancy. Pregnancy-related mortality is known to be undercounted in vital statistics records, and there is concern that it may be increasing in Washington. It is particularly important to monitor as it represents the severe end of pregnancy-related morbidity. For every death that occurs, several women experience pregnancy-related complications.

To evaluate the current surveillance system, all deaths to Washington resident women ages 15-44 from 1990 through 1998 were linked to births, fetal deaths and obstetric hospitalizations within 364 days prior to the death. Of the 8,016 deaths to women during this time period, 266 deaths were pregnancy-associated, occurring within 364 days of delivery. Fifty percent of these deaths were due to injuries, the majority of which were motor vehicle crashes (42.1% of all injury deaths). While most injury deaths were unintentional (53.4%), homicides accounted for 25.6%, and suicides for 11.3%. Forty-four of the 266 pregnancy-associated deaths were determined to be pregnancy-related (caused by pregnancy or by a condition that was exacerbated by pregnancy or its management). The maternal mortality ratio for the period was 6.2/100,000 live births. In addition, nine deaths were possibly pregnancy-related, but more information was needed for classification. The major causes of the pregnancy-related deaths included: embolism, infection, hemorrhage and cardiac conditions. While the numbers of these deaths are low, maternal mortality ratios were elevated for Blacks and Asian/Pacific Islanders, for women age 35 and over, and women who did not receive prenatal care.

Over the same time period, 27 deaths were identified by the current vital statistics based system for a maternal mortality ratio of 3.8 per 100,000 live births. This amounts to a 74% underestimation of pregnancy-related deaths. The linkage to birth and fetal death certificates identified almost all of the newly identified cases with few cases identified only from hospitalization data.

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[i] Since the early 1970s, the Department of Health has contracted with tertiary level perinatal referral centers to provide regionalized services for pregnant women and newborns as part of the continuing effort to support the national concept of regionalized perinatal care. The activities of our four perinatal programs are essential for improving pregnancy outcome, decreasing maternal and infant morbidity and mortality, and decreasing incidence of low birth weight and prematurity. Regionalization provides physician and nurse consultation services, continuing education for health care professionals, emergency medical transport for referring hospitals within the region, and medical care for high-risk pregnant women and newborns, advisory support to the Department of Health and DSHS, Medical Assistance Administration, and the statewide Perinatal Advisory Committee (PAC).

[ii] A statewide Perinatal Advisory Committee was formed by the Washington State Department of Health in December 1985. Members represent regional perinatal programs, hospitals with obstetrical/neonatal services, perinatal/neonatal professional organizations for physicians, nurses, midwives, social workers, and public health officials, to

- identify and prioritize statewide perinatal concerns

- identify need, produce materials as needed, and make recommendations through specific work groups to address perinatal issues

provide consultation and recommend prioritized solutions to the Department of Health and DSHS (Medicaid)

[iii] This medical record is used by 90% of the prenatal medical providers in WA state. It was developed and is maintained by Physicians Insurance, the largest medical liability provider for OBs in the state. We worked with PI to revise the record to improve screening and documentation of critical issues related to content of prenatal care (GBS, HIV, DV etc.)

[iv] Genetics contract with Children's Hospital from Oct '03-May '04 to assess feasibility of telemedicne, and now a new contract with Children's (July 8, 04-May 31, 05) to do a pilot study, meet with area physicians to promote the pilot, develop protocols, create a patient booklet, and write an evaluation report.

[v] The purpose of the *Living Room Forums (LRF)* is to assess the attitudes, knowledge and understanding of genetics issues by the general public and to see if this approach can be used to further disseminate genetics awareness among the general population. For each forum, a local newspaper will be invited to publish an article about the forum written by the recorder (a UW graduate student) with help from the Genetic Services Section staff. LRF will be audiotaped by the recorder to ensure accuracy, especially of quotes from participants used in the news articles. In addition, the articles published will include a referral to the DOH web page where readers can go to enter their opinions on the questions asked of the *LRF* participants. It's hypothesized that the articles generated will raise awareness of genetics issues for the general public and *Letters to the Editor* generated in response to the featured articles will be monitored along with the number of hits to the *LRF* web page.

Draft Combined List of Priorities For All of the MCH Populations : Hyperlinks

Priority	INFANTS	PREGNANT WOMEN/ WCBA	SCHOOL AGE CHILDREN	EARLY CHILDHOOD
1. Promote adequate nutrition and physical activity	▪ Infants_Adequate nutrition_P1	▪ Women_Healthy lifestyles_P1235789	▪ School Age_Promotion of Nutrition&PA_P1	▪ Early Childhood_Nutrition and Physical Activity_P1
2. Promote lifestyles free of substance use and addiction	▪ Infants_Safe and Healthy Environment_P245	▪ Women_Tobacco free_P2 ▪ Women_App alcohol use/ drug free_P2 ▪ Women_Healthy lifestyles_P1235789	▪ School Age_Substance Use_P2	
3. Promote positive mental health and healthy relationships	▪ Infants_social/ emotional development_P3	▪ Women_Healthy relationships_P3 ▪ Women_Healthy lifestyles_P1235789	▪ School Age_Injury Prevention_P3 ▪ School Age_Growth and Development_P3689 ▪ School Age Mental Health_P3689	▪ Early Childhood_Prevent Child abuse and neglect_P345 ▪ Early Childhood_Promote school readiness_P3689 ▪ Early Childhood_Mental Health_P3
4. Promote a healthy physical and social environment	▪ Infants_Safe and Healthy Environment_P245	▪ Women_Safe and healthy environment_P45	▪ School Age_EnvHealth_P4	▪ Early Childhood_Healthy and Safe Communities_P45 ▪ Early Childhood_Prevent Child abuse and neglect_P345
5. Promote a safe and injury free community	▪ Infants_Safe and Healthy Environment_P245	▪ Women_Safe and healthy environment_P45 ▪ Women_Healthy relationships_P35 ▪ Women_Healthy lifestyles_P1235789	▪ Violence and Unintentional Injury Prevention	▪ Early Childhood_Prevent Child abuse and neglect_P345 ▪ Early Childhood_Healthy and Safe Communities_P45
6. Promote healthy physical growth and cognitive development	▪ Promote fine and gross motor development, cognitive development, and communication skills		▪ School Age_Growth and Development_P3689 ▪ School Age Mental Health_P3689	▪ Early Childhood_Promote school readiness_P3689 ▪
7. Promote sexual health and sexual responsibility		▪ Sexually responsible and healthy women_P7 ▪ Women_Healthy lifestyles_P1235789	▪ School Age_Sexual Health_P7	
8. Promote access to preventive and treatment services	▪ Infants_Access to well child care_P8 ▪ Women_Access to services_P8 ▪ Medical insurance ▪ Infant_medical home_P8	▪ Women_Access to services_P8 ▪ Women_Healthy lifestyles_P1235789	▪ School Age_Growth and Development_P3689 ▪ School Age Mental Health_P3689	▪ Early Childhood_Promote school readiness_P3689
9. Promote quality screening, identification, and intervention and care coordination	▪ Women_Prenatal Care Quality Svcs_P9 ▪ Infants_EarlyIntervention_P9	▪ Women_Prenatal Care Quality Svcs_P9 ▪ Women_High quality care Women CBA_P9 ▪ Women_Healthy lifestyles_P1235789	▪ School Age_Growth and Development_P3689 ▪ School Age Mental Health_P3689	▪ Early Childhood_Early identification and coordination_P9 ▪ Early Childhood_Promote school readiness_P3689

Appendix F: Example of Issue Brief